Maryland
GOVERNOR'S OFFICE OF CRIME PREVENTION, YOUTH, AND VICTIM SERVICES

Maryland Governor's Office of Crime Prevention, Youth, and Victim Services
Sexual Assault Reimbursement Unit (SARU)
100 Community Place, Crownsville, MD 21032

Authorization For Sexual Assault Forensic Medical Examination

This form is to be submitted with an itemized bill, and UB-04 CMS-1450 or OMB-0938-1197 1500 form. Submit mandatory forms for reimbursement to the Sexual Assault Reimbursement Unit (SARU) within 90 days of the exam. Reimbursement claims are subject to the guidelines of the SARU. All fields must be completed. Please provide a remittance address if it is different from the facility address.

Patient Information

Patient Full Name:_____
(Last) (First) (Middle)

Patient DOB: _____ **Patient Medical Record Number**: _____
(mm/dd/yy)

Patient Age: _____ **Patient Race**: _____

Patient Gender: ☐ Male ☐ Female ☐Transgender ☐ Other: _____

Patient Address: _____
(County) (Zip Code)

Date & Time of Sexually-Based or Sexually Related Crime: _____
(mm/dd/yy) (Approximate Time)(AM/PM)

Location of Sexually-Based or Sexually Related Crime: _____
(City/County/State)

Date and Time of Forensic Exam: _____
(mm/dd/yy) (Approximate Time) (AM/PM)

Blind Report/Anonymous Exam: ☐ YES ☐ NO

Police Department Contacted: _____ **Officer Name**: _____

_____
(Badge #) (District) (Phone)

Police Case Number OR Property Held Number: _____

Other Case Number or Identifier:_____

Healthcare Facility Information

Healthcare Facility:_____

Healthcare Professional Conducting Examination: _____

Facility Phone Number: _____ **Facility Fax**: _____

Billing Email Address: _____

Appointment Type: ☐ Initial Examination ☐ Follow Up Care

Authorization for Medical Examination, Collection of Evidence, and Release of Information

I hereby authorize _____ and _____
(Hospital) (Qualified Healthcare Professional/Examiner)
to conduct a medical assessment and treatment which may include a sexual assault forensic exam to gather information and evidence as to an alleged sexual assault, including the collection of blood, urine, tissue, or other specimens and clothing and the taking of photographs and/or video.

In addition, I hereby authorize the transmittal of the below list of forensic medical services and treatment rendered to me to the Criminal Injuries Compensation Board's Sexual Assault Reimbursement Unit (SARU) for the purpose of providing the authority for the SARU to pay the physician, qualified healthcare provider, or hospital for the services rendered to me and for the collection of evidence. I understand that my personal information including medical chart, narrative of the assault, and photographs/video cannot be disclosed as a requirement to obtain reimbursement pursuant to Criminal Proceedings §11-1007.

Signed: _____
(Print Name) (Signature)
Relationship to patient: _____ Date: _____
(self, guardian, authorized individual) (mm/dd/yy)

Physician Certification of Sexual Assault Treatment to Validate Reimbursement

I hereby attest and affirm to the best of my knowledge that _____ (Patient's full name) was treated for injuries sustained as a result of alleged rape, sexual assault, or child sexual abuse in accordance with COMAR 10.12.02.5.I certify that any items billed to the SARU for reimbursement are for the treatment of injuries sustained as a result of alleged **rape, sexual assault, or child sexual abuse**.

Signed: _____
(Treating Physician) (Print) (Signature) (License #)

Date: _____
(mm/dd/yy)

Patient Name: _____

Medical Services

☐ Medical Screening Examination ☐ Forensic Exam ☐ Radiology ☐ Surgical Consult
☐ Other (please explain):_____

Signature: _____
Forensic Nurse Examiner (License #)

Laboratory Services

Blood Panels: ☐ CBC ☐ CMP
Pregnancy Test: ☐ Serum ☐ Urine (HCG Qualitative only)

Sexually Transmitted Infections:
☐ Genital culture ☐ Urine NAAT ☐ Wet Prep
☐ Gonorrhea: ☐ *Oral* ☐ *Rectal* ☐ *Vaginal*
☐ Chlamydia: ☐ *Oral* ☐ *Rectal* ☐ *Vaginal*
☐ Trichomoniasis ☐ RPR, VDRL, Syphilis ☐ Herpes Culture ☐ Hepatitis Panel ☐ HIV antigen/antibody
☐ Rectal Culture

Drug Facilitated Sexual Assault (DFSA):
Was DFSA suspected? ☐ Yes ☐ No
If yes, please select all laboratory services rendered:
☐ Toxicology Panel (see attached invoice):
☐ Urine ☐ Blood
☐Other/Explain:_____

Prescribed Medications

Emergency Contraception: ☐ Yes ☐ No
Pain Medication: ☐ Tylenol (Acetaminophen) ☐ Motrin (Ibuprofen) ☐ Lidocaine ☐ Ketorolac
Antibiotics: ☐ Rocephin (Ceftriaxone) ☐ Flagyl (Metronidazole) ☐ Doxycycline ☐ Zithromax (Azithromycin) ☐ Suprax (Cefixime) ☐ Cipro (Ciprofloxin) ☐ Erythromycin ☐ Levaquin (Levofloxacin)
Vaccines: ☐ Tetanus ☐ Hepatitis ☐ Human Papillomavirus (HPV) ☐ Hepatitis B Immune Globulin (HBIG)
Prophylaxis: ☐ nPEP therapy*
If patient receives nPEP therapy, complete the nPEP/HIV Prophylaxis Treatment and Reimbursement Claim Form
Anti-nausea: ☐ Zofran (Ondansetron)
☐ Other/Explain:_____

Authorization For Sexual Assault Forensic Examination Continued

Patient Name: _____

Required Data

Was the patient assessed for exposure to HIV? ☐ Yes ☐ No

Did the patient qualify to receive nPEP? ☐ Yes ☐ No

Did the patient choose to receive nPEP? ☐ Yes* ☐ No

Complete and submit the separate nPEP/HIV Prophylaxis Treatment Reimbursement Claim & Prescription Form

Did the patient elect to receive nPEP treatment without a SAFE exam? ☐ Yes ☐ No

Was a follow-up care referral made? ☐ Yes ☐ No

If yes, where: _____

Number of days/doses of nPEP treatment provided at facility: ☐ 1 ☐ 3 ☐ 5 ☐ 7 ☐ 28 Other: _____

(A "sexually-based assault" includes any rape, sexual assault, or sexual child abuse as outlined in Maryland Criminal Law Articles 3-303 through 3-308).